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§ 155.120 Non-interference with Federal law and non-discrimination standards.

(a) *Non-interference with Federal law.* An Exchange must not establish rules that conflict with or prevent the application of regulations promulgated by HHS under subtitle D of title I of the Affordable Care Act.

(b) *Non-interference with State law.* Nothing in parts 155, 156, or 157 of this subchapter shall be construed to preempt any State law that does not prevent the application of the provisions of title I of the Affordable Care Act.

(c) *Non-discrimination.* In carrying out the requirements of this part, the State and the Exchange must:

(1) Comply with applicable non-discrimination statutes; and

(2) Not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.

§ 155.130 Stakeholder consultation.

The Exchange must regularly consult on an ongoing basis with the following stakeholders:

(a) Educated health care consumers who are enrollees in QHPs;

(b) Individuals and entities with experience in facilitating enrollment in health coverage;

(c) Advocates for enrolling hard to reach populations, which include individuals with mental health or substance abuse disorders;

(d) Small businesses and self-employed individuals;

(e) State Medicaid and CHIP agencies;

(f) Federally-recognized Tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, that are located within such Exchange's geographic area;

(g) Public health experts;

(h) Health care providers;

(i) Large employers;

(j) Health insurance issuers; and

(k) Agents and brokers.

§ 155.140 Establishment of a regional Exchange or subsidiary Exchange.

(a) *Regional Exchange.* A State may participate in a regional Exchange if:

(1) The Exchange spans two or more States, regardless of whether the States are contiguous; and

(2) The regional Exchange submits a single Exchange Blueprint and is approved to operate consistent with §155.105(c).

(b) *Subsidiary Exchange.* A State may establish one or more subsidiary Exchanges within the State if:

(1) Each such Exchange serves a geographically distinct area; and

(2) The area served by each subsidiary Exchange is at least as large as a rating area described in section 2701(a) of the PHS Act.

(c) *Exchange standards.* Each regional or subsidiary Exchange must:

(1) Otherwise meet the requirements of an Exchange consistent with this part; and

(2) Meet the following standards for SHOP:

(i) Perform the functions of a SHOP for its service area in accordance with subpart H of this part; and

(ii) Encompass the same geographic area for its regional or subsidiary SHOP and its regional or subsidiary Exchange except:

(A) In the case of a regional Exchange established pursuant to §155.100(a)(2), the regional SHOP must encompass a geographic area that matches the combined geographic areas of the individual market Exchanges established to serve the same set of States establishing the regional SHOP; and

(B) In the case of a subsidiary Exchange established pursuant to §155.100(a)(2), the combined geographic area of all subsidiary SHOPs established in the State must encompass the geographic area of the individual market Exchange established to serve the State.

[77 FR 11718, Feb. 27, 2012, as amended at 78 FR 54134, Aug. 30, 2013]

§ 155.150 Transition process for existing State health insurance exchanges.

(a) *Presumption.* Unless an exchange is determined to be non-compliant through the process in paragraph (b) of this section, HHS will otherwise presume that an existing State exchange meets the standards under this part if:

(1) The exchange was in operation prior to January 1, 2010; and

(2) The State has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of the Affordable Care Act, according to the Congressional Budget Office estimates for projected coverage in 2016 that were published on March 30, 2011.

(b) *Process for determining non-compliance.* Any State described in paragraph (a) of this section must work with HHS to identify areas of non-compliance with the standards under this part.

§ 155.160 Financial support for continued operations.

(a) *Definition.* For purposes of this section, participating issuers has the meaning provided in § 156.50.

(b) *Funding for ongoing operations.* A State must ensure that its Exchange has sufficient funding in order to support its ongoing operations beginning January 1, 2015, as follows:

(1) States may generate funding, such as through user fees on participating issuers, for Exchange operations; and

(2) No Federal grants under section 1311 of the Affordable Care Act will be awarded for State Exchange establishment after January 1, 2015.

§ 155.170 Additional required benefits.

(a) *Additional required benefits.* (1) A State may require a QHP to offer benefits in addition to the essential health benefits.

(2) A State-required benefit enacted on or before December 31, 2011 is not considered in addition to the essential health benefits.

(3) The Exchange shall identify which state-required benefits are in excess of EHB.

(b) *Payments.* The State must make payments to defray the cost of additional required benefits specified in paragraph (a) of this section to one of the following:

(1) To an enrollee, as defined in § 155.20 of this subchapter; or

(2) Directly to the QHP issuer on behalf of the individual described in paragraph (b)(1) of this section.

(c) *Cost of additional required benefits.* (1) Each QHP issuer in the State shall quantify cost attributable to each additional required benefit specified in paragraph (a) of this section.

(2) A QHP issuer's calculation shall be:

(i) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(ii) Conducted by a member of the American Academy of Actuaries; and

(iii) Reported to the Exchange.

[78 FR 12865, Feb. 25, 2013]

Subpart C—General Functions of an Exchange

§ 155.200 Functions of an Exchange.

(a) *General requirements.* The Exchange must perform the minimum functions described in this subpart and in subparts D, E, F, G, H, and K of this part unless the State is approved to operate only a SHOP by HHS pursuant to § 155.100(a)(2), in which case the Exchange operated by the State must perform the minimum functions described in subpart H and all applicable provisions of other subparts referenced therein while the Exchange operated by HHS must perform the minimum functions described in this subpart and in subparts D, E, F, G, and K of this part.

(b) *Certificates of exemption.* The Exchange must issue certificates of exemption consistent with sections 1311(d)(4)(H) and 1411 of the Affordable Care Act.

(c) *Oversight and financial integrity.* The Exchange must perform required functions related to oversight and financial integrity requirements in accordance with section 1313 of the Affordable Care Act.

(d) *Quality activities.* The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act.

(e) *Clarification.* In carrying out its responsibilities under this subpart, an